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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAVID J. BENAVIDES, a.k.a. DAVID JONATHAN BENAVIDES 8272 Branchoak Court Elk Grove, CA 95758 Registered Nurse License No. 449961 Respondent.	Case No. 2009-288 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1990, the Board issued Registered Nurse License Number 449961 to David J. Benavides, also known as David Jonathan Benavides ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2010, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

5. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
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> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or

violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS AT ISSUE

8. "Morphine/morphine sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

9. "Demerol", a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. At all times relevant herein, Respondent was employed as a registered nurse in the post anesthesia care unit (PACU) at Methodist Hospital, Sacramento, California.

11. On or about February 7, 2005, K.S., a 39 year old female patient, had undergone surgery for gastric bypass with resection of a gastric tumor under general anesthesia, and was taken to PACU in stable condition. The patient's anesthesiologist, Dr. Greg Miller, reported to registered nurse Ronni Frank that the patient was allergic to Demerol. A PCA (patient controlled anesthesia) pump was started before the patient's arrival to the PACU, and the drug infusing was morphine sulfate. Dr. Miller and Nurse Frank were controlling the patient's pain with IV doses of Fentanyl 25 mcg (a total of 200 mcg had been ordered for the patient; Nurse Frank had administered a total of 100 mcg); and morphine sulfate 4 mg (a total of 20 mg had been ordered for the patient; Nurse Frank had administered the total dose of 20 mg). The patient's pain was controlled at 4/10 as of 1540 hours.

12. At approximately 1540 hours, Respondent assumed care of the patient and administered Benadryl 50 mg. to the patient. At approximately 1545 hours, Respondent administered morphine sulfate 4 mg to the patient, and a total of 50 mg Demerol between 1555 and 1605 hours.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that Respondent was

guilty of gross negligence in his care of patient K.S. within the meaning of Regulation 1442, as follows:

a. Respondent administered morphine sulfate 4 mg to the patient without a written or telephone order from Dr. Miller,[1] and when the patient had already been administered the full ordered dose of 20 mg.

b. Respondent administered Demerol 50 mg to the patient when he knew that the patient was allergic to Demerol. Further, Respondent administered the Demerol without a written or telephone order from Dr. Miller.

c. Respondent failed to document the patient's pain level while caring for the patient between 1540 and 1615 hours.

d. Respondent falsified the patient's records by adding or writing orders for Benadryl and Demerol in the Anesthesia Post-Op Orders as if they had been issued by Dr. Miller. (Respondent wrote an order for Demerol 25 or 50 mg by IV every five minutes to a maximum of 100 mg, and an order for Benadryl 50 mg by IV "now").

SECOND CAUSE FOR DISCIPLINE

(Prescribing and Unlawful Administration of Controlled Substances)

14. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10 through 13 above.

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that on or about February 7, 2005, while employed as a registered nurse in the PACU at Methodist Hospital, Sacramento, California, Respondent did the following:

Prescribing Controlled Substances:

a. Respondent wrote an order for the controlled substance Demerol, as set forth in subparagraph 13 (d) above.

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1. When hospital staff, including Dr. Miller, Nurse Frank, and Respondent, were questioned as to how to obtain new orders for a patient, they stated that the anesthesiologist was reachable by telephone.

Unlawful Administration of Controlled Substances:

b. Respondent administered the controlled substances morphine sulfate and Demerol to patient K.S. without lawful authority therefor, as set forth in subparagraphs 13 (a) and (b) above.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

16. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10 through 13 above.

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on or about February 7, 2005, while employed as a registered nurse in the PACU at Methodist Hospital, Sacramento, California, Respondent falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's records pertaining to the controlled substance Demerol, and the drug Benadryl, as set forth in subparagraph 13 (d) above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 449961, issued to David J. Benavides, also known as David Jonathan Benavides;

2. Ordering David J. Benavides, also known as David Jonathan Benavides, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 5/12/2009

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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